MAINE
Patient Centered
Medical Home Pilot

FOR DISCUSSION
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MaineCare Services
An Office of the
Department of Health and Human Services

Maine PCMH Pilot – Phase 2 Expansion

&

MaineCare Health Homes Initiative

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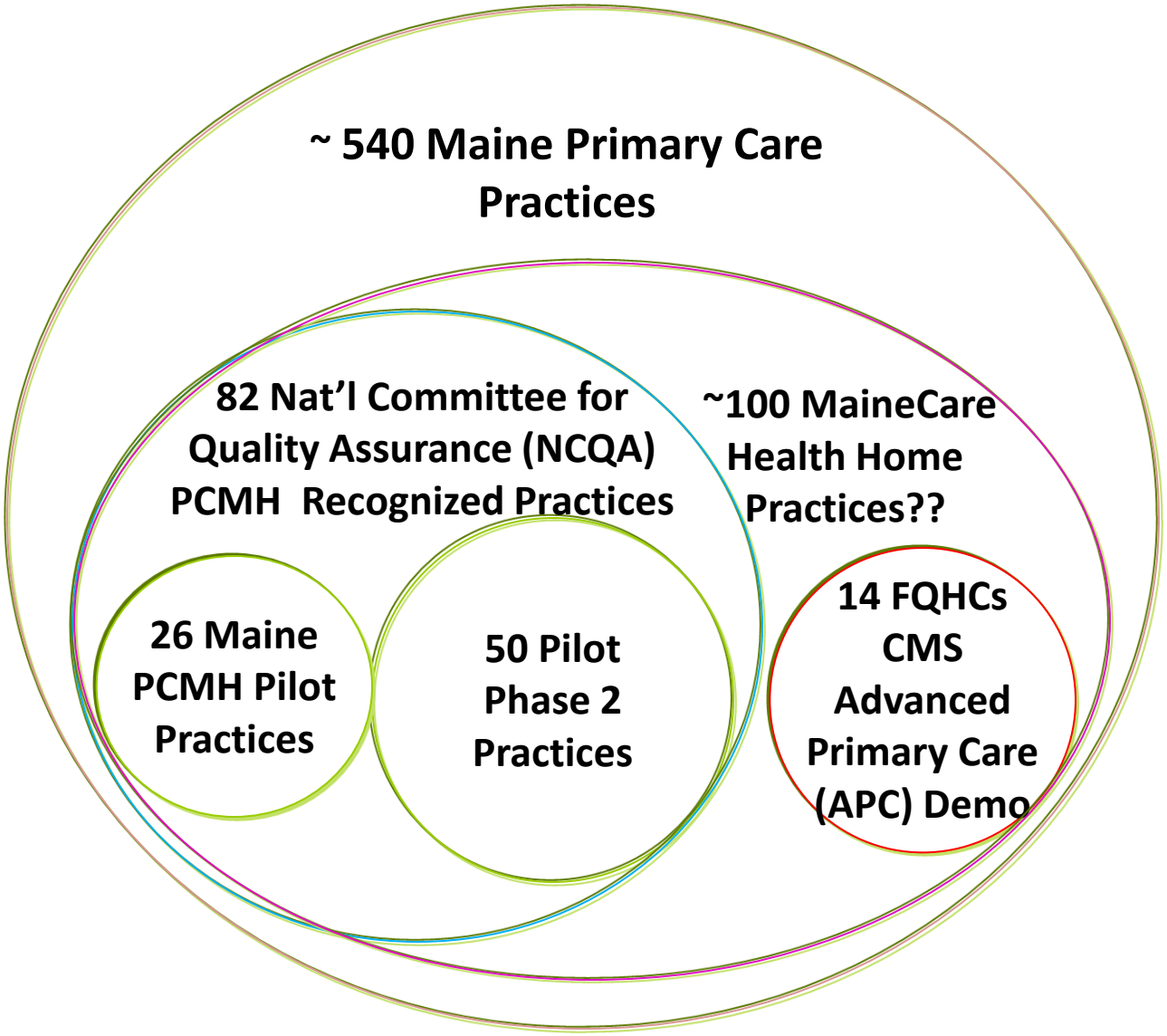
April 2012

Maine's Medical Home Movement



Defining Medical Home Model

"A **medical home** is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective."

- American Academy Pediatrics (1964)

Maine Patient Centered Medical Home (PCMH) Pilot

Key elements:

- Convened by Maine Quality Forum, Maine Quality Counts, Maine Health Management Coalition
- Originally, 3-year multi-payer PCMH pilot (now 5 yrs)
- Collaborative effort of key stakeholders, major payers
- Adopted common mission & vision, guiding principles for Maine PCMH model
- Selected 22 adult / 4 pediatric PCP practices across state
- Supporting practice transformation & shared learning beyond pilot practices
- Committed to engaging consumers/ patients at all levels
- Conducting rigorous outcomes evaluation (clinical, cost, patient experience of care)

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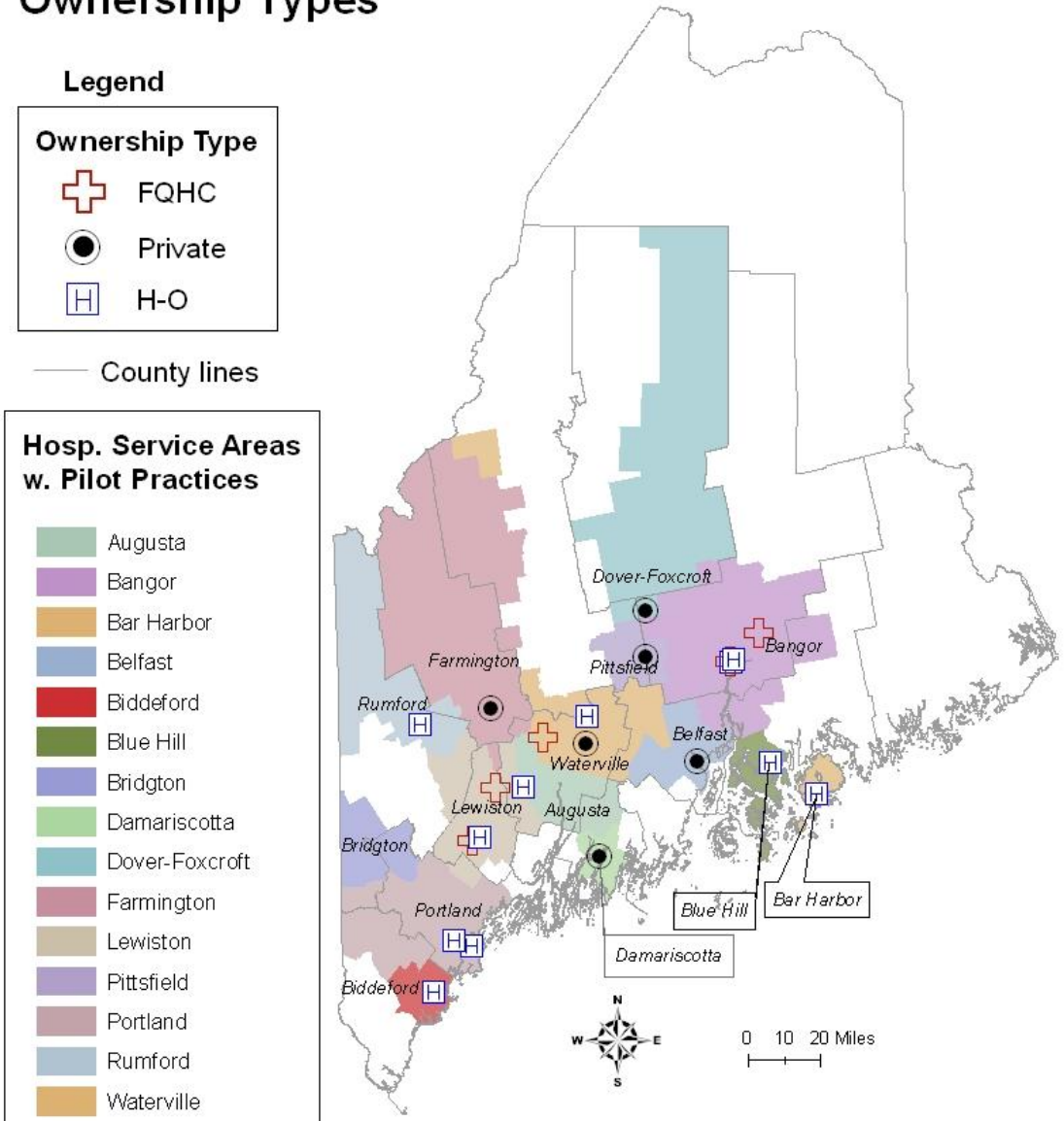
Maine PCMH Pilot Practices
Ownership Types



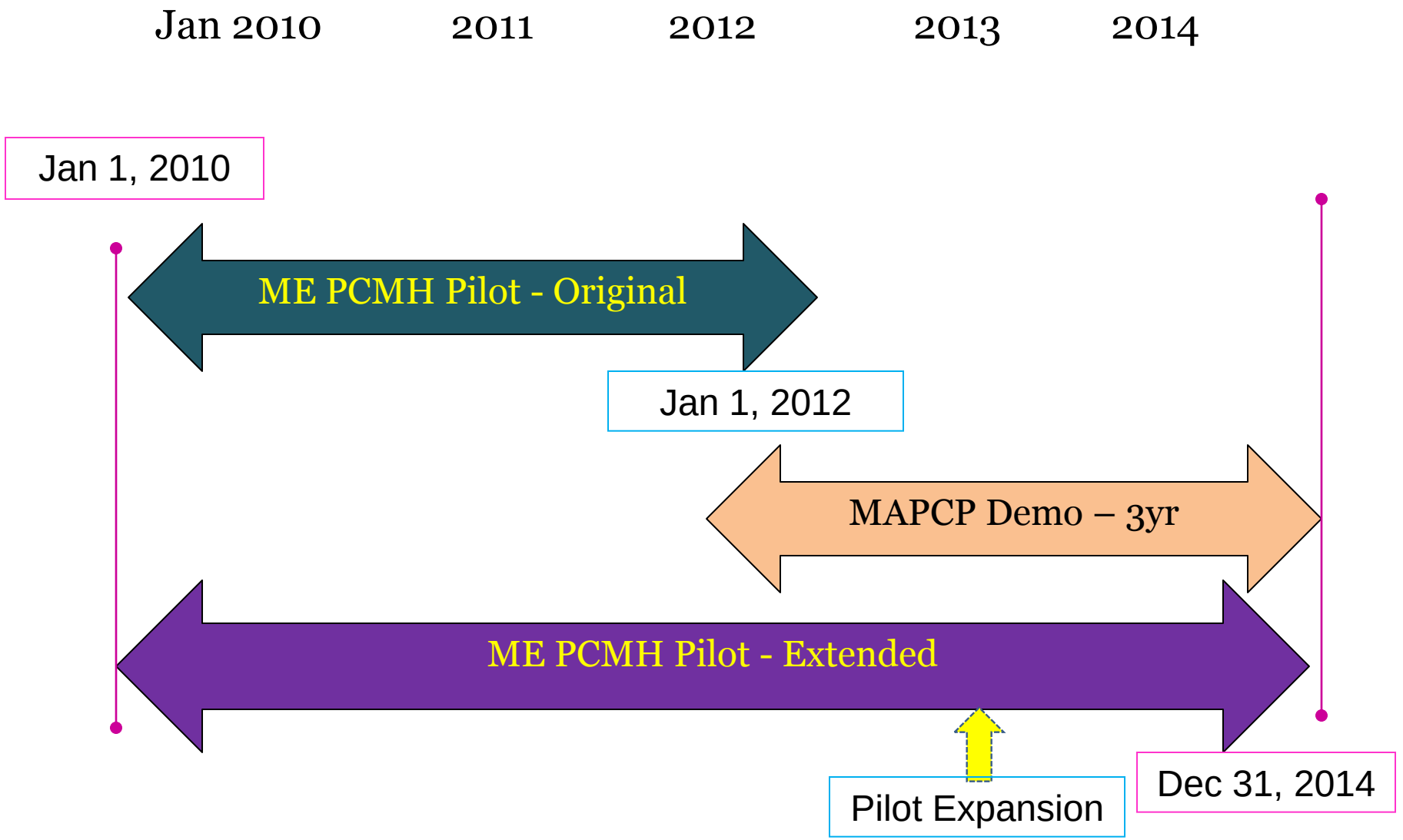
Maine PCMH Pilot
Practice "Core Expectations"

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local HMP
9. Commitment to waste reduction
10. Patient-centered HIT

Maine PCMH Pilot Payment Model

- Major private payers participating: Anthem, Aetna, HPHC, Medicaid & Medicare (through the Medicare Advanced Primary Care practice (MAPCP) Demonstration)
- Using “standard” 3-component payment:
  - Prospective per member per month (pmpm) care management payment – approx $3 pmpm commercial & Medicaid; $7 pmpm Medicare
  - Ongoing fee for service (FFS) payments
  - Performance payment for meeting quality targets (existing pay for performance programs)

Maine PCMH Pilot-MAPCP Timeline



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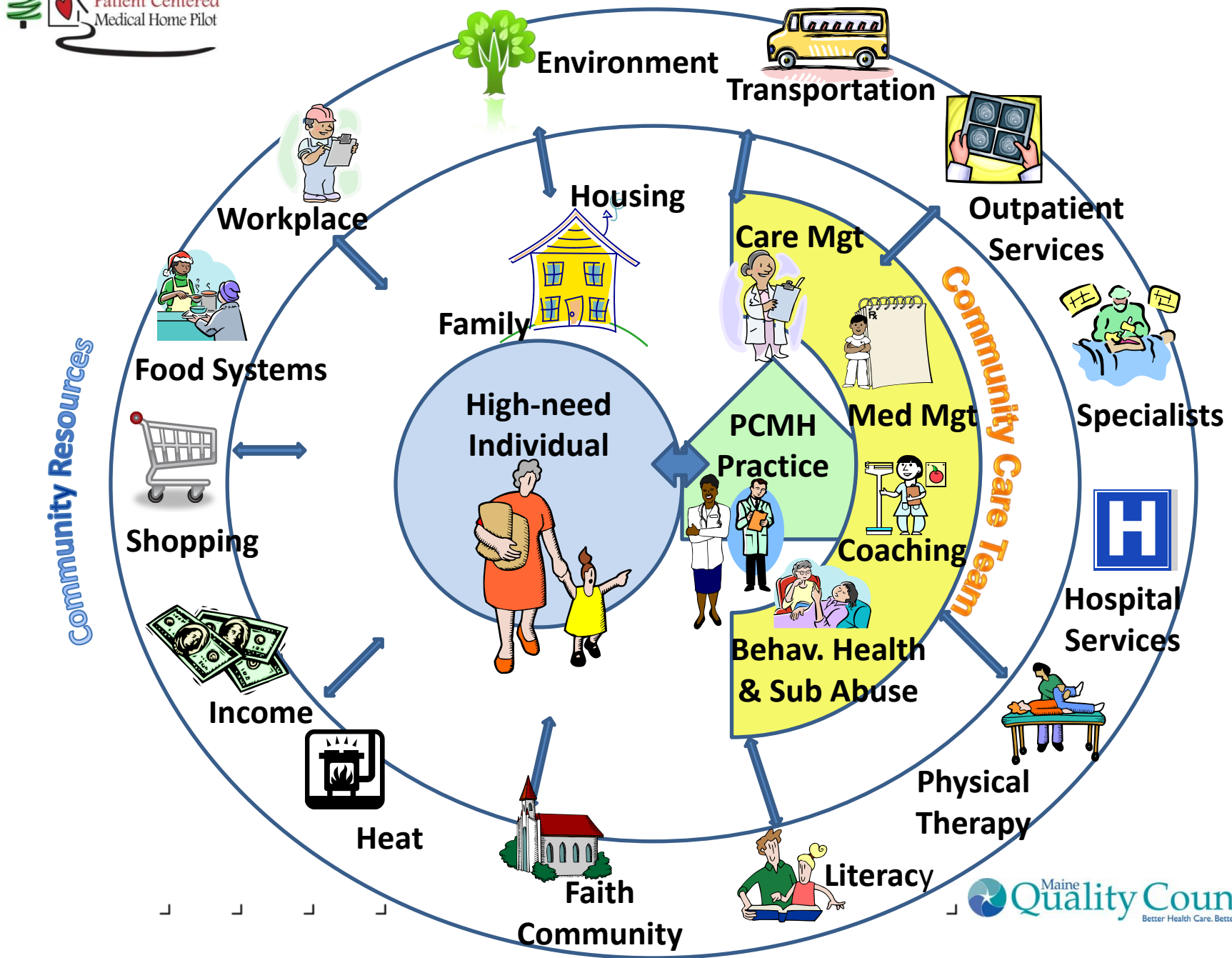
Community Care Teams

- Multi-disciplinary, community-based, practice-integrated care teams
- Build on successful models (NC, VT, NJ)
- Support patients & practices in Pilot sites, helping patients overcome barriers to care, improve outcomes
- Receive pmpm payments from Medicaid, Medicare, commercial payers
- Key element of cost-reduction strategy, targeting high-cost patients to reduce avoidable costs (ED use, admits)

Maine PCMH Pilot Community Care Teams



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Current ME PCMH Pilot CCTs

- Androscoggin Home Health
- Coastal Care Team (Blue Hill FP, Community Health Center/Mount Desert Island, Seaport FP)
- Community Health Partners (Newport FP, Dexter FP)
- DFD Russell
- Eastern Maine Homecare
- Kennebec Valley (MaineGeneral)
- Maine Medical Center
- Penobscot Community Health Center

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Pilot Phase 2 Expansion

- 50 new adult practices to be selected for participation in multi-payer Pilot
- Will enter Pilot (with payment) Jan 2013
- Expectations:
  - Strong leadership for change
  - NCQA PCMH recognition (Level 1 or higher)
  - Fully implemented Electronic Medical Record (EMR)
  - Commitment to implement Pilot Core Expectations

CMS Health Homes – ACA Section 2703

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- CMS will provide 90/10 match for Health Home services to eligible members for eight quarters
- CMS must approve Medicaid "State Plan Amendment"
- Health Homes may serve individuals with:
  - Two or more chronic conditions
  - One chronic condition and who are at risk for another
  - Serious mental illness
    - Adults with serious mental illness (SMI)
    - Children with severe emotional disturbance (SED)
- Dual eligible beneficiaries cannot be excluded from Health Home services

CMS Health Homes – ACA Section 2703

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Chronic conditions

(per CMS):

- Mental health
- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Overweight (BMI > 25) & Obesity

Maine-specific

(pending CMS approval):

- Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Hyperlipidemia
- Tobacco use
- Developmental Disabilities & Autism Spectrum
- Acquired brain injury
- Children only: Cardiac & circulatory congenital abnormalities
- Children only: Seizure disorder

CMS Health Homes – ACA Section 2703

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Required Health Home services include:

- Comprehensive care management
- Care coordination and health promotion
- Comprehensive transitional care from inpatient to other settings
- Individual and family support
- Referral to community and social support services
- Use of health information technology (HIT)
- Prevention and treatment of mental illness and substance abuse disorders
- Coordination of and access to preventive services, chronic disease management, and long-term care supports

Maine's Health Homes Proposal

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Medical Homes

\+

Community Care Teams (CCTs)

=

Health Homes

Maine Health Homes Proposal

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Stage A:

- Health Home = Medical Home primary care practice + CCT
- Payment weighted toward medical home
- Eligible Members:
  - Two or more chronic conditions
  - One chronic condition and at risk for another

Stage B:

- Health Homes = CCT with behavioral health expertise + Medical Home primary care practice
- Payment weighted toward CCT
- Eligible Members:
  - Adults with Serious Mental Illness
  - Children with Serious Emotional Disturbance

Maine Health Homes Proposal

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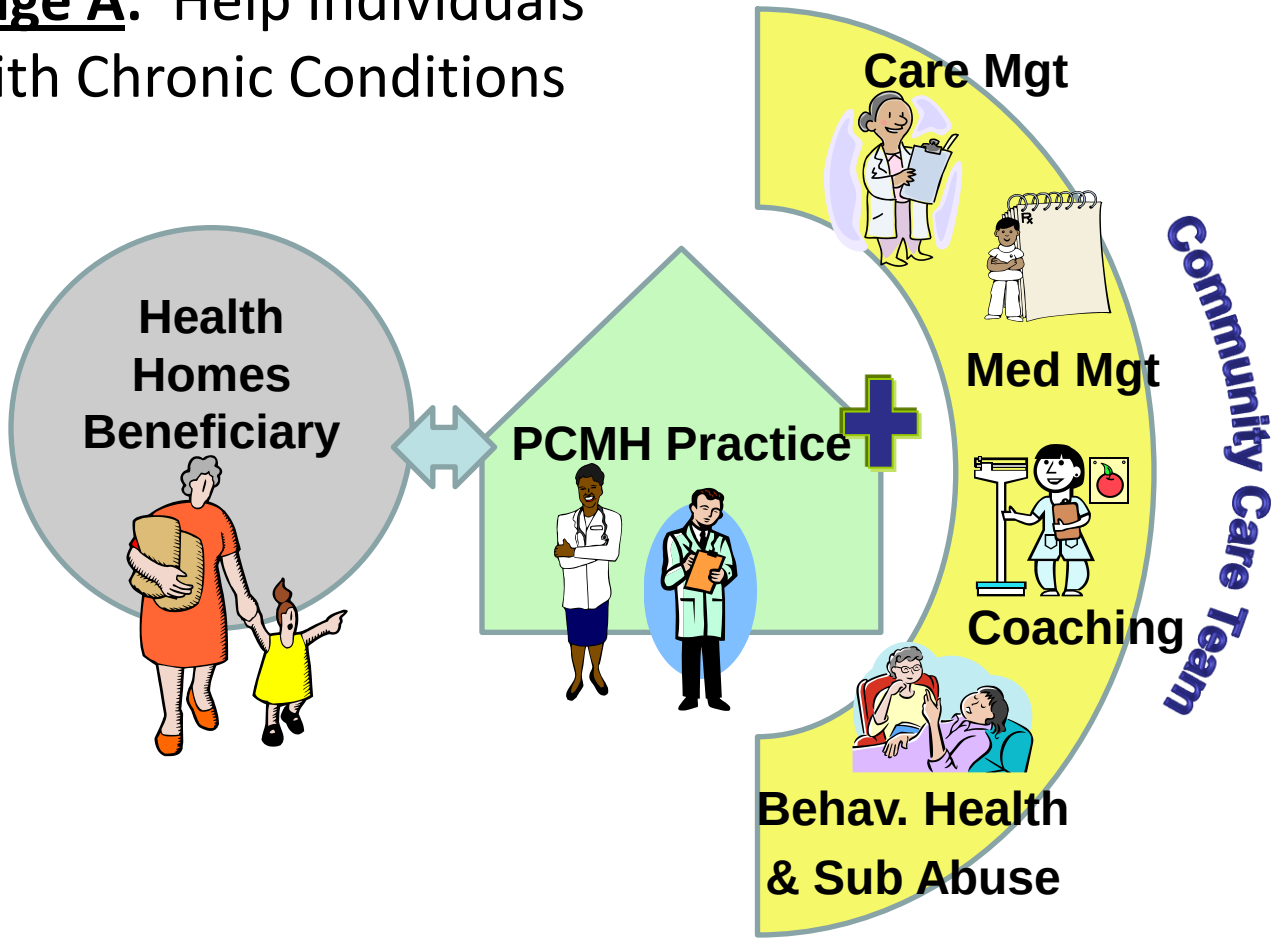
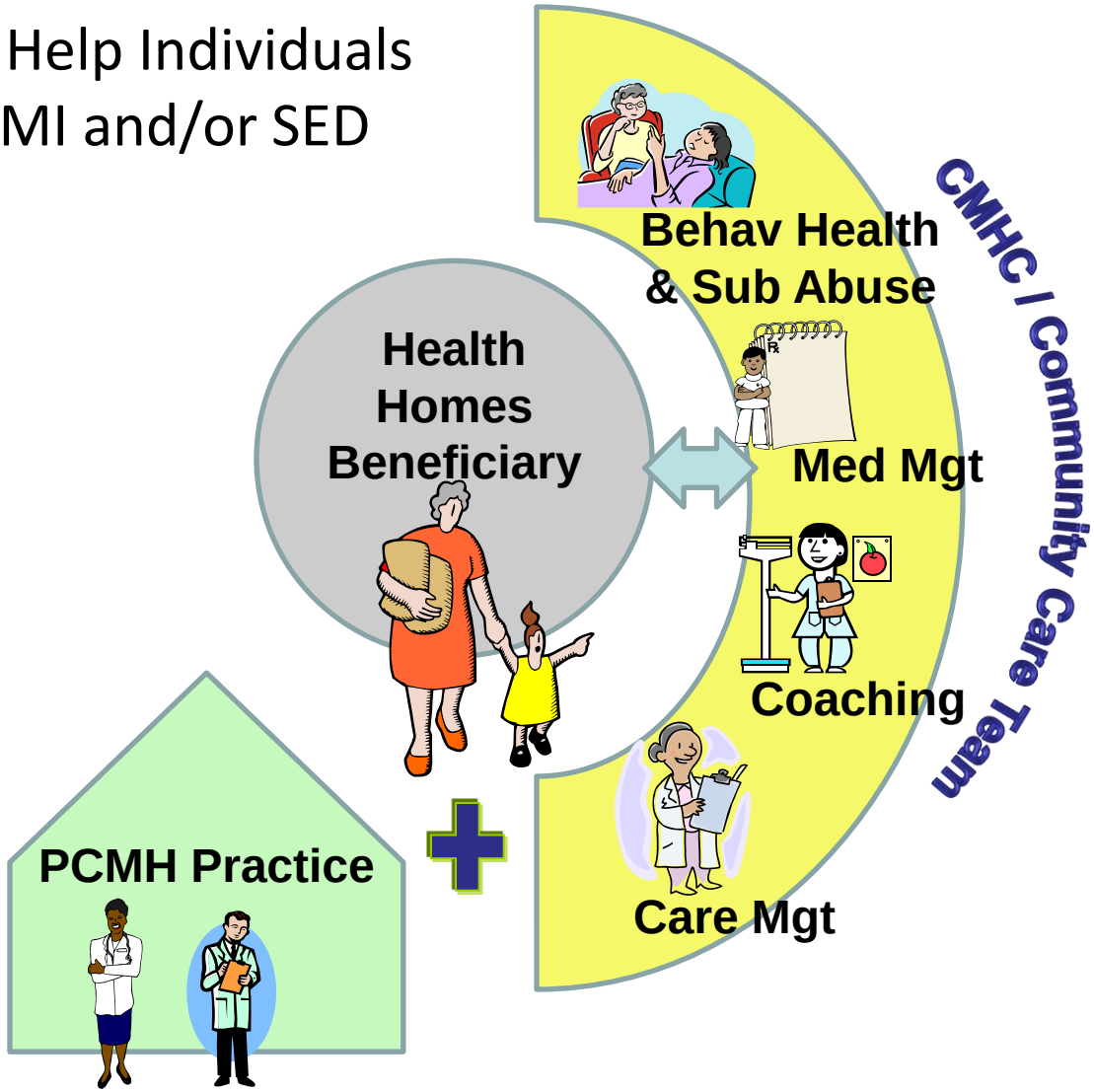
Stage A: Help Individuals with Chronic Conditions



Maine Health Homes Proposal

<u>Stage B</u>: Help Individuals with SPMI and/or SED



CMS Health Homes – Required Measures

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- Core Set – Quality Measures
  - Adult BMI assessment
  - Ambulatory Sensitive Condition admission rate
  - Care transitions record transmitted to PCP (within 24hrs)
  - Follow up after mental health admission
  - All-cause 30 day readmission rate
  - Depression screening & follow up
  - Initiation & engagement of treatment for alcohol/drug dependence
- State-Specific Goals & Measures
  - State must set HH measurable goals (e.g reduce ED visits)
  - Must identify measures to operationalize those goals

Proposed Maine-Specific Quality Measures

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- Claims-based measures:
  - ED admissions- overall and inappropriate
  - Follow-up after any hospitalization
  - Inappropriate imaging rate
  - Well child visits (pediatrics)
  - Lead screening (pediatrics)
- Multi-payer PCMH Pilot clinical quality metrics (once we have the technological capacity to facilitate collection without over burdening providers)

Pilot Expansion & Health Homes Application

Process:

- Interested practices apply through joint PCMH Pilot/ Health Homes online application
  - http://www.surveymonkey.com/s/ME_PCMH_Pilot_Phase2_Expansion_Applic
  - Due by May 4, 2012 (application re-opened on April 20)
- 50 practices will be selected for multi-payer PCMH Pilot Phase 2 expansion
- All other practices meeting basic qualifications will be eligible to become MaineCare Health Home
- CCTs will be selected through separate application process (June-July 2012)

Pilot Expansion & Health Homes Application

Eligibility – MaineCare Health Homes:

- Pediatric or Adult Primary care practice site with at least one full-time primary care physician or nurse practitioner
- NCQA PCMH recognition (Level 1 or higher) application submitted by time of selection (June 30, 2012)
- Fully implemented EMR
- Commitment to meet Maine PCMH 10 Core Expectations
- Commitment to provide CMS-mandated Health Homes services
- Agreement to identify Maine PCMH Pilot Community Care Team (CCT) to partner in managing high-needs patients

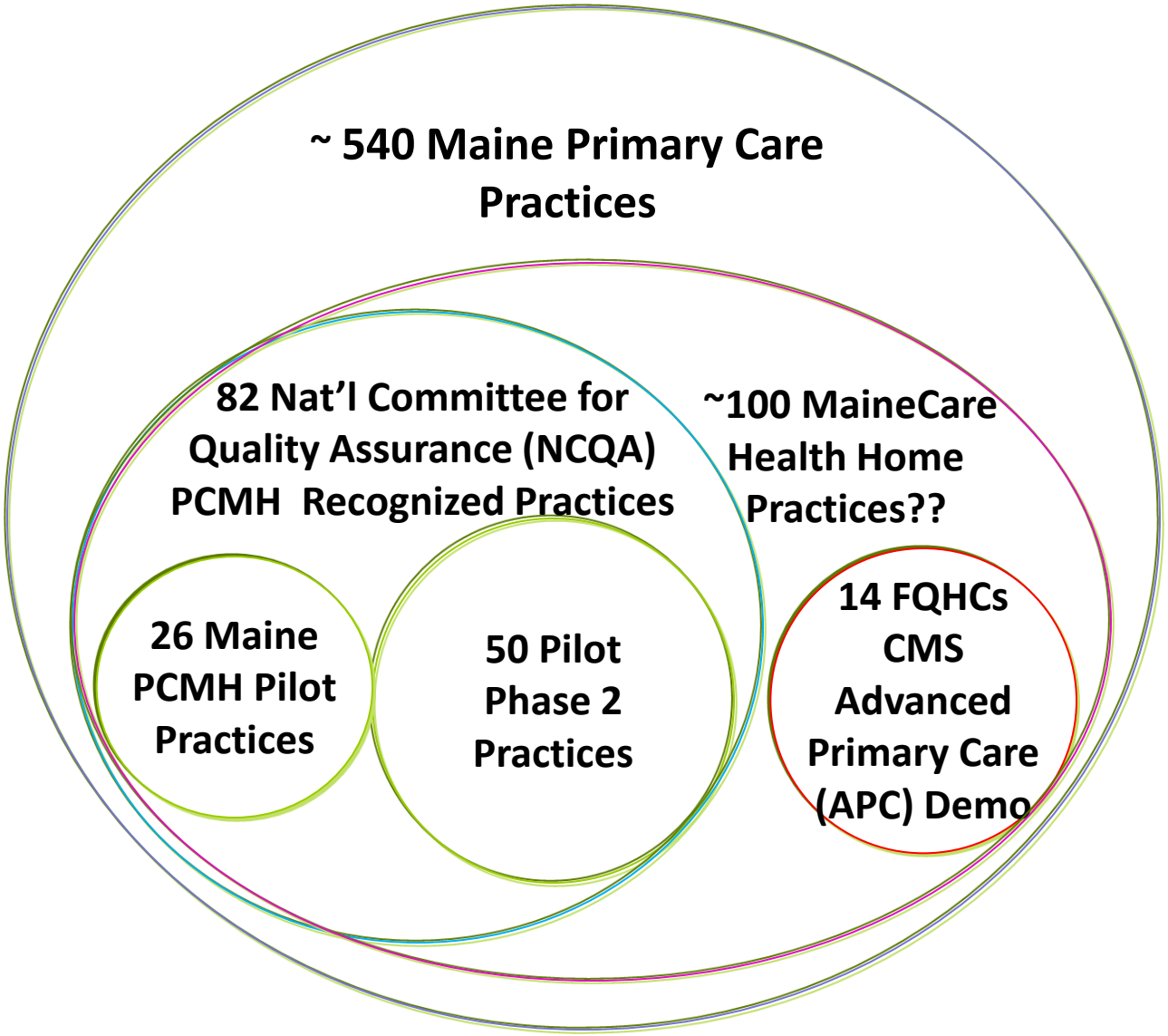
Eligibility – Maine PCMH Pilot Expansion:

- Practice meets MaineCare Health Home requirements
- Adult primary care practice site with at least one full-time primary care physician or nurse practitioner
- Practice site does **not** currently participate in the CMS FQHC Advanced Primary Care (APC) Demonstration
- Minimum patient panel of 1000+ patients enrolled in Pilot health plans (Anthem BCBS, Aetna, Harvard Pilgrim Health Care, MaineCare, and Medicare).
- Completion of Maine PCMH Pilot Phase 2 Expansion "Memorandum of Agreement" (MOA)
- Agreement to contribute modest PMPM toward practice transformation support

PCMH Pilot & Health Homes Stage A Timeline

- April 20 – May 4, 2012 – Online practice application process re-opened
- **Friday, May 4, 2012 (5PM) - Deadline for practices to submit online application**
- May - June 2012 – Review of practice applications by PCMH Pilot Selection Committee
- June 29, 2012 - Phase 2 practices selected
- July 2, 2012 – Phase 2 Community Care Team (CCT) application posted online
- August 15, 2012 – Deadline for CCTs to submit online application
- September 1, 2012 – Phase 2 CCTs selected
- October 2012: Health Homes Stage A implementation (estimated)
- January 1, 2013 – Phase 2 practices and CCTs enter Maine PCMH Pilot

Maine's Medical Home Movement



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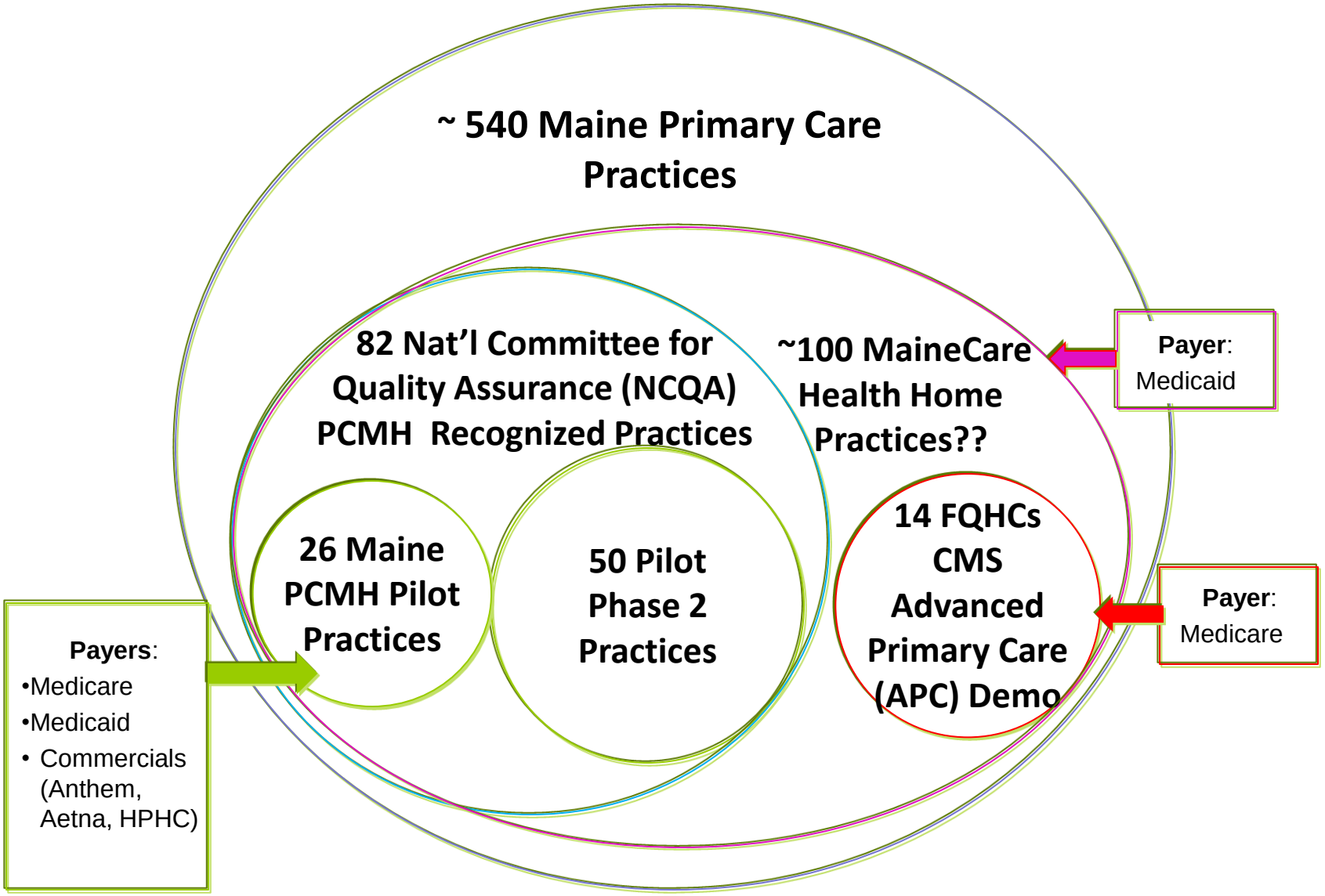

MAINE Patient Centered Medical Home Pilot

www.mainequalitycounts.org

Maine Quality Counts
Better Health Care. Better Health.

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Programs

- Patient Centered Medical Home
- Aligning Forces for Quality
- QC Learning Community
- Behavioral Health Integration
- Pressure Ulcer Prevention
- Electronic Health Records to Improve Care
- Patient Family Leadership Team
- IHOC - Quality Counts for Kids
- Community Health Teams
- Transforming Care at the Bedside
- AF4Q Equity - ME Race, Ethnicity and Language Initiative

PCMH Links

- PCMH Home
- Assessing Practice Readiness
- Support for Practice Transformation
- Tools and Resources

Patient Centered Medical Home

Recognizing the essential role of primary care in our healthcare system, the Maine Quality Forum (MQF), *Quality Counts*, and the Maine Health Management Coalition are working together to lead the Maine Patient Centered Medical Home (PCMH) Pilot. Following an initial planning period, the group selected a group of 26 primary care practices in May 2009 to implement the PCMH model as a first step in ultimately achieving the goal of statewide implementation of a patient centered medical home model.

PCMH Learning Session 6: The Medical Home Run

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Learning Session 6 for the Patient Centered Medical Home Pilot was held on Friday, June 3rd. The program focused on reducing avoidable health care costs. The day-long Session provided opportunities for the Pilot practice teams to learn more about steps they can take, in collaboration with their "medical neighbors", to address the important task of working together to reduce avoidable health care costs. One of the speakers, Arnold Milstein, based his talk on his 2008 blog entitled *Medical Homes—And Medical 'Home Runs'*. This posting can be found at: http://healthaffairs.org/blog/2008/09/10/medical-homes-and-medical-home-runs. Some of the presentation slides and handouts from this session are now available.

Read more... Add new comment

PCMH Learning Session 5 a Success!

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The Maine Patient Centered Medical Home Pilot's

Payment Model & Financial Case for PCMH

PDF | | Print | | E-mail

The Case for Enhanced Payment for

www.maine.gov/dhhs/oms/vbp

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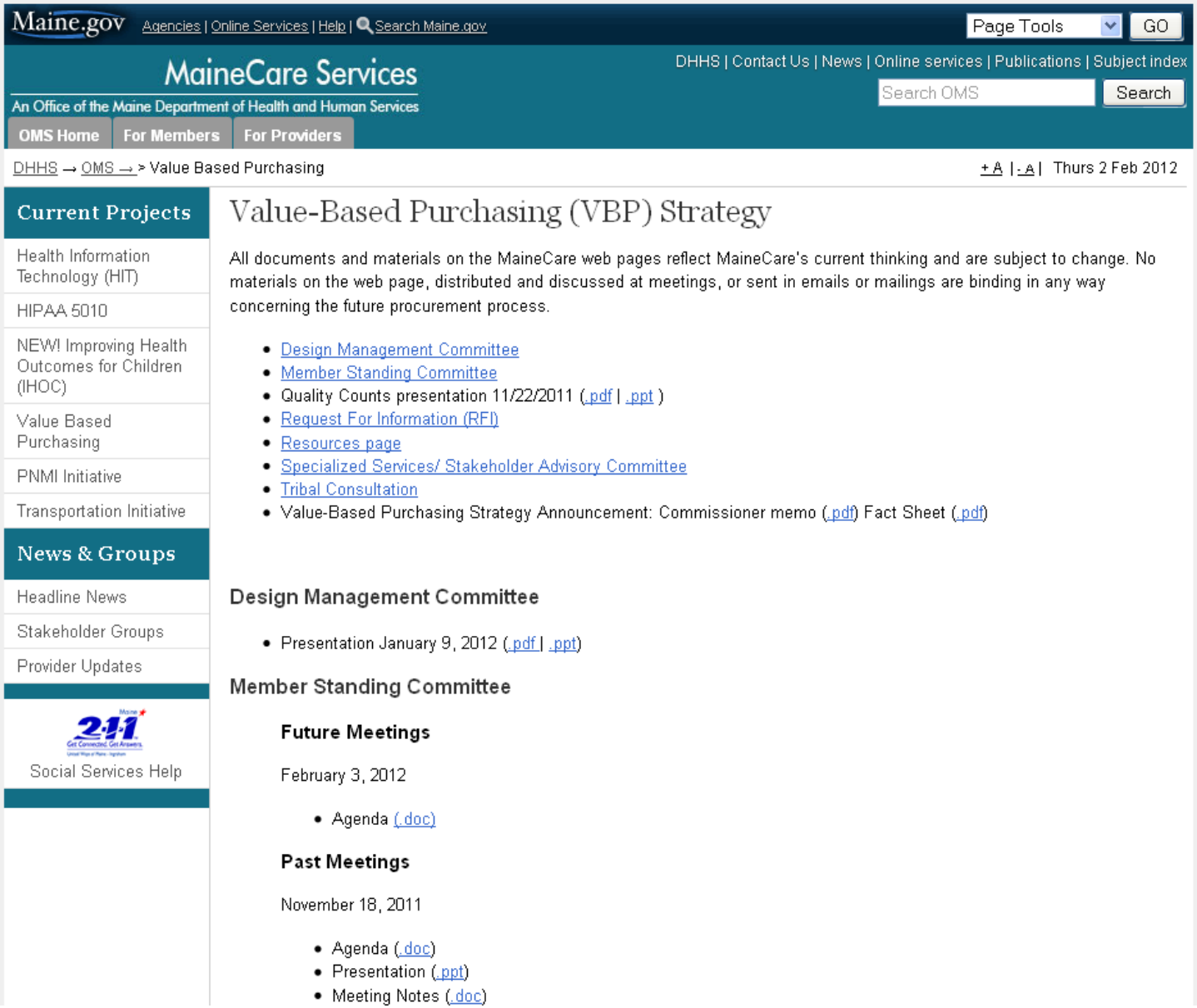

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+A | -A | Thurs 2 Feb 2012

Current Projects

- Health Information Technology (HIT)
- HIPAA 5010
- NEW! Improving Health Outcomes for Children (IHOC)
- Value Based Purchasing
- PNMI Initiative
- Transportation Initiative

News & Groups

- Headline News
- Stakeholder Groups
- Provider Updates

211 Maine — Get Connected. Get Answers.
Social Services Help

Value-Based Purchasing (VBP) Strategy

All documents and materials on the MaineCare web pages reflect MaineCare's current thinking and are subject to change. No materials on the web page, distributed and discussed at meetings, or sent in emails or mailings are binding in any way concerning the future procurement process.

- Design Management Committee
- Member Standing Committee
- Quality Counts presentation 11/22/2011 (.pdf | .ppt)
- Request For Information (RFI)
- Resources page
- Specialized Services/ Stakeholder Advisory Committee
- Tribal Consultation
- Value-Based Purchasing Strategy Announcement: Commissioner memo (.pdf) Fact Sheet (.pdf)

Design Management Committee

- Presentation January 9, 2012 (.pdf | .ppt)

Member Standing Committee

Future Meetings

February 3, 2012

- Agenda (.doc)

Past Meetings

November 18, 2011

- Agenda (.doc)
- Presentation (.ppt)
- Meeting Notes (.doc)

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Contact Info / Questions

- Maine PCMH Pilot: www.mainequalitycounts.org

  (See "Major Programs" → "PCMH Pilot")

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- MaineCare Health Homes
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